

6071

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>42 Pocomoke City</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pocomoke City, Md 42</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 212 Maple St.</i>				STREET ADDRESS (If rural give location) <i>212 Maple Street 1</i>			
3. NAME OF DECEASED: (First) <i>Rosa</i> (Middle) <i>Mag</i> (Last) <i>dydelotte</i>				4. DATE OF DEATH: (Month) <i>June</i> (Day) <i>7</i> (Year) <i>1955</i>			
5. SEX: <i>2</i>	6. COLOR OR RACE: <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Feb 10 1895</i>	9. AGE last birthday: <i>59</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Mln.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Chicken plant</i>		11. BIRTHPLACE (State or foreign country): <i>Poultney New church Va</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Mellie Marshall</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-05-5710</i>		17. INFORMANT & ADDRESS: <i>John L. dydelotte 212 Maple St. Pocomoke City Md</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE <i>002X</i>				(A) <i>Hemorrhage of Lung</i>			
ANTECEDENT CAUSE (S)				DUE TO <i>T.b. of lung</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>260X</i>				(B) <i>Diabetes</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				(C) <i>Diabetes</i>			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug. 1954</i> to <i>June 1955</i> that I last saw the deceased alive on <i>June 6, 1955</i> , and that death occurred at <i>100 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>R. E. Sartorius</i>				DATE SIGNED <i>5/8/55</i>			
23. BURIAL, CREMATION, REBURY (SPECIFY) <i>Reburial</i>		DATE THEREOF <i>6-12-55</i>		NAME OF CEMETERY OR CREMATORY <i>Wares town</i>		LOCATION (City, town, or county) (State) <i>Pocomoke Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 12, 1955</i>		REGISTRAR'S SIGNATURE <i>Anne E. White</i>		24. FUNERAL DIRECTOR <i>Edgar Wharton</i>		ADDRESS <i>New Church</i>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 15 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06080

Item 7 Film 183 6-27-55 et
6072

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pocomoke</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke city, md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
First Middle Last <u>Carry Bell</u>				<u>June 11 1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>C.</u>		7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>August 14, 1897</u>	
				9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer Junker</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Calverton, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Ernest Bell</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Little</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>26-14-8026</u>		17. INFORMANT & ADDRESS: <u>Ellen Darden, Pocomoke</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of stomach</u>							<u>5 mos</u>
ANTECEDENT CAUSE (B) <u>Post operative</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION: <u>13/20/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of stomach - far advanced</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/25</u> , 19 <u>55</u> , to <u>6/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>55</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arvine M. Bedford</u>		ADDRESS <u>M.D. 508-5 - one Pocomoke</u>		DATE SIGNED <u>6/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>6-17-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Richards Memorial Park, Va.</u>		LOCATION (City, town, or county) (State): <u>Richards Memorial Park, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>June 20, 1955</u>		REGISTRAR'S SIGNATURE: <u>Anne E. White</u>		24. FUNERAL DIRECTOR: <u>Edgar Richards</u>		ADDRESS: <u>Richards Memorial Park, Va.</u>	

BUREAU V. S.

JUN 22 1955

RECEIVED

6074

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Berlin		LENGTH OF STAY (in this place) About 4 Mos.		CITY (If outside corporate limits, write RURAL and give nearest town) Berlin			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Route # 3				STREET ADDRESS (If rural give location) Route # 3			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) Elizabeth		(Middle)		(Last) Buddick		(Month) 6 - 3 (Dry) (Year) 19 55	
5. SEX: Female		6. COLOR OR RACE: A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 7-8-31	
9. AGE last birthday: 23 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 25		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer				10b. KIND OF BUSINESS OR INDUSTRY: Peanut Factory		11. BIRTHPLACE (State or foreign country): Franklin, Southampton Co. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME: Edward Henry				14. MOTHER'S MAIDEN NAME: Maria Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 230-46-4515		17. INFORMANT & ADDRESS: Mr. Samuel Hendricks, Franklin, Va.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Constrictive heart failure		2 days
Antecedent causes (s) (b) Rheumatic heart disease		9 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		

11. OTHER SIGNIFICANT CONDITIONS		12. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from March 19, 1955 , to June 3, 1955 , that I last saw the deceased alive on June 3, 1955 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
SIGNATURE U. Suley, Jr.		DATE SIGNED June 4, 1955	
(Degree or title)		ADDRESS Berlin, Md	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		DATE THEREOF 6-4-55	
NAME OF CEMETERY OR CREMATORY Franklin Cemetery		LOCATION (City, town, or county) (State) Franklin, Southampton Co. Va.	
DATE REC'D BY LOCAL REGISTRAR 6-4-55		REGISTRAR'S SIGNATURE Helen F. Hayward	
24. FUNERAL DIRECTOR Mary A. Stewart		ADDRESS 324 E. Church St., Salisbury, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

[illegible]

6075

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Snow Hill</i>	LENGTH OF STAY (in this place) <i>60 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>James</i>	(Middle) <i>Wilby</i>	(Last) <i>Battingham</i>	DEATH: <i>June 2 1955</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>Dec. 7 - 1894</i>
9. AGE last birthday <i>60</i>		10. AGE last birthday <i>60</i>	11. AGE last birthday <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>70</i>	11. BIRTHPLACE (State or foreign country): <i>Snow Hill md</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <i>Jonathan Battingham</i>	
14. MOTHER'S MAIDEN NAME: <i>Virginia Wilby Battingham</i>		15. INFORMANT & ADDRESS: <i>mf Wilby Battingham, Snow Hill, md</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i>		17. SOCIAL SECURITY NO. <i>70</i>	
18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>420.1 Acute Coronary Occlusion</i>		10 Hours	
ANTECEDENT CAUSE (B) <i>Hypertensive Cardiovascular Disease</i>		5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June</i> , 1951., to <i>June 2</i> , 1955, that I last saw the deceased alive on <i>June 2</i> , 1955, and that death occurred at <i>8:15 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Robert L. Loman</i>		DATE SIGNED <i>6-3-55</i>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <i>June 5, 55</i>		LOCATION (City, town, or county) <i>Snow Hill md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 4, 55</i>		FUNDING DIRECTOR ADDRESS <i>Walter C. Cooper, Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

RECEIVED

: 6076

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Berlin</u>	LENGTH OF STAY (in this place) <u>65</u>	CITY (If outside corporate limits, write TOWN and give nearest town) <u>Berlin</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>R2D (Ironshire)</u>	/
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>RICHARD</u>	(Middle) <u>CRANFIELD</u>	(Last) <u>CRANFIELD</u>	OF DEATH: <u>JUNE 20 1955</u>
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>JUNE 20, 1889</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own FARM</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>GEORGE CRANFIELD</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Gladys Mitchell, Berlin, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>acute myocarditis</u>			
ANTECEDENT CAUSE (B) <u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.	
22. I hereby certify that I attended the deceased from <u>53</u> , to <u>6-20-55</u> , that I last saw the deceased alive on <u>6-18-55</u> , and that death occurred at <u>10:18</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Clifford E. Schott</u>		ADDRESS <u>Berlin Md.</u> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/23/55</u>	
<u>Evergreen</u>		<u>Berlin Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>June 23, 1955</u>		<u>Helen F. Hayward</u>	
<u>Anna R. Burboze</u>		<u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

JUN 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6077

06084

Reg. Dist. No. 353

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Worcester</u> - MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Ocean City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bath Ave at 6th St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>D.C.</u> COUNTY _____ CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> STREET ADDRESS (If rural, give location) <u>3717 Warren St. N.W.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Edward</u> (First) <u>Francis</u> (Middle) <u>CRONIN</u> (Last)		4. DATE OF DEATH 6 25 19 55	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Sept. 14 1936</u>
9. AGE last birthday: <u>18</u> yrs.		10. IF UNDER 1 YEAR: _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY: _____	
11. BIRTHPLACE (State or foreign country): <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Thomas J. CRONIN</u>		14. MOTHER'S MAIDEN NAME: <u>Nora Magrath</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>T.J. Cronin, father, Wash D.C.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>929.8</u> Immediate cause (a) <u>Drowning, accidental</u> DUE TO _____ Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH: <u>20 minutes</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: _____			
19a. DATE OF OPERATION: _____		19b. MAJOR FINDING OF OPERATION: _____	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Ocean</u>	21c. (City or town) <u>Ocean City</u> (County) <u>Wor</u> (State) <u>Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 25 4 44 PM 1955</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>while bathing in Ocean</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>J. J. J. J. J.</u>		CHIEF MEDICAL EXAMINER <u>J. J. J. J. J.</u> DATE SIGNED <u>June 26 55</u> DEPUTY MEDICAL EXAMINER _____ ASSISTANT MEDICAL EXAM. _____	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/29/55</u>	NAME OF CEMETERY OR CREMATORY: <u>St. John's</u>	LOCATION (City, town, or county) (State): <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>June 26, 1955</u>	REGISTRAR'S SIGNATURE: <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR: <u>Anna D. Burbage</u> ADDRESS: <u>Bethesda Md</u>	

BUREAU V. 1

JUN 29 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6078

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>R.F.D. #1</u>				Snow Hill, Maryland X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 Home				Snow Hill, Md. /			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Sidney Edward Drummond				June 26 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M.	C.	Married	Feb. 26, 1880	75 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Farm		Virginia		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Purnell Drummond				Annie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		None		Christeana S. Drummond Snow Hill, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.1 IMMEDIATE CAUSE (A) DUE TO						48 hours	
ANTECEDENT CAUSE (B) DUE TO						Weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Several years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 2/23, 1955, to 6/22, 1955, that I last saw the deceased alive on 6/22, 1955, and that death occurred at 1:00 AM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
J. U. Evely, Jr.		M.D. Berlin, Md		6/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-29-55		Bayside		Oranock Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
June 29, 1955		Clayton E. Cooper		Edgar Whorton		New Church, Va.	

07239

BUREAU V. 2

JUL 12 1935

RECEIVED

6079

06085

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	
<i>X</i> <i>Berlin Road #3</i>	<i>2 Weeks</i>	<i>Shutland</i>	<i>22X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Raymond</i>	(Middle) <i>Duncan</i>	(Last)	(Month) (Day) (Year)
(Type or Print)			<i>June 21 1955</i>
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH:
<i>male</i>	<i>White</i>	<i>Married</i>	<i>April 7-1994</i>
9. AGE last birthday:	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>61-2-18 yrs.</i>	<i>Hired Hand</i>	<i>Snow Hill, md</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Samuel Duncan</i>		<i>May Wright</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<i>No</i>		<i>None</i>	
17. INFORMANT'S ADDRESS:		18. MEDICAL CERTIFICATION	
<i>Edith Simmons Berlin, md</i>		<i>Road #3</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
163X Immediate cause (a) <i>Asphyxia</i>		<i>5 min.</i>	
Antecedent cause(s) (b) <i>Hemorrhage in Trachea</i>		<i>15 min.</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>Carcinoma Right Lungs</i>		<i>1 yr.</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>Fracture Right Tibia Nov. 1954</i>	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>J. L. La Mar</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6-23-55</i>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>June 24/55</i>	<i>Layton Gate</i>	<i>Snow Hill md</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	VENERAL DIRECTOR ADDRESS	
<i>June 23, 1955</i>	<i>John F. Hayward</i>	<i>Wayne V. Morris, Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 27 1955

BUREAU V. S.

1 6073

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>42 Pocomoke</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	<u>42</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 Market Street</u>		STREET ADDRESS (If rural give location) <u>Market Street</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH	
(First) <u>Henry</u>	(Middle) <u>R.</u>	(Last) <u>Triggs</u>	<u>June 23 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Oct 10-1881</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William L. Triggs</u>		14. MOTHER'S MARDEN NAME: <u>Jane Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr Francis Triggs Pocomoke Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
290.0 IMMEDIATE CAUSE		(A) <u>Acute heart failure</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Chronic Myocarditis</u>	
		DUE TO	
		(C) <u>Per. Anemia</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>over exertion Non information</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> to <u>June 23</u> , 19 <u>55</u> that I last saw the deceased alive on <u>June 23</u> , 19 <u>55</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. E. Santorini</u>		DATE SIGNED <u>June 24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Salim M. E. Cemetery Pocomoke Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 25, 1955</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Henry S. Watson</u>		<u>Pocomoke Md.</u>	

BUREAU V. E.

JUN 27 1955

RECEIVED

6080

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Snow Hill</i>		TOWN <i>Snow Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<i>William Sidney Godfrey</i>		<i>June 16 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Widowed</i>	8. DATE OF BIRTH: <i>Sept 8 - 1861</i>
9. AGE last birthday: <i>93-9-8</i>		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Retired Farmer Own Farm</i>		<i>Snow Hill, md</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Snow Hill, md</i>			
13. FATHER'S NAME: <i>William J Godfrey</i>		14. MOTHER'S MAIDEN NAME: <i>Mar A. Marcus</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>None</i>	
17. INFORMANT & ADDRESS:			
<i>Miss Margie E Godfrey, Snow Hill, md</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <i>Acute Pulmonary Edema</i>		14 Hours	
ANTECEDENT CAUSE (S) (B) <i>myocardial insufficiency</i>		3 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Acute Coronary Occlusion</i>		14 Hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1943</i> 19....., to <i>June 16</i> , 1955, that I last saw the deceased alive on <i>June 16</i> , 1955, and that death occurred at <i>11:00 AM</i> from the causes and on the date stated above.			
SIGNATURE <i>Robert L. LaMar</i>		DATE SIGNED <i>June 17-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Bates Memorial</i>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<i>June 19, 55</i>		<i>Snow Hill md</i>	
REGISTRAR'S SIGNATURE <i>Clayton E. Cooper</i>		FUNERAL DIRECTOR ADDRESS <i>Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 28 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

07241

351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write and give nearest town) <i>Snow Hill</i>		RURAL <input checked="" type="checkbox"/> LENGTH OF STAY (in this place) <i>62 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		OR TOWN <i>Snow Hill</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>Emily</i>		(Middle) <i>Bell</i>		(Last) <i>Halloway</i>		(Month) <i>June</i> (Day) <i>30</i> (Year) <i>1955</i>	
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>		8. DATE OF BIRTH: <i>April 25-1863</i>	
9. AGE last birthday <i>92</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Homemaker</i>		11. BIRTHPLACE (State or foreign country): <i>Parsonburg, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Samuel Riley</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Jane Bethard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No. <i>None</i>		17. INFORMANT & ADDRESS: <i>Mrs Ralph E Shashly Snow Hill, md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>422.1</i>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>1904.7</i>							
(A) <i>Acute Pulmonary Edema</i>						1 day	
(B) <i>Myocardial Infarction + Arteriosclerosis</i>						5 yrs	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture Left Femur</i>						3 months	
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>January, 1955</i> , to <i>June 30, 1955</i> , that I last saw the deceased alive on <i>June 30, 1955</i> , and that death occurred at <i>7:45 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Edmund La Mar</i>				ADDRESS <i>Snow Hill</i>		DATE SIGNED <i>7-1-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 4/55</i>		NAME OF CEMETERY OR CREMATORY <i>Honest Lane</i>		LOCATION (City, town, or county) (State) <i>Parsonburg, md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>July 2, 55</i>		REGISTRAR'S SIGNATURE <i>Edmund E. Cooper</i>		24. FUNERAL DIRECTOR <i>Wm. E. Morris</i>		ADDRESS <i>Snow Hill, md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 12 1955

RECEIVED

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6082

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ocean City</u>		LENGTH OF STAY (in this place) <u>1 week</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>14</u> <u>3 vol 4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Caroline Street</u>				STREET ADDRESS (If rural, give location) <u>4605 Elsode Ave</u> ✓			
3. NAME OF DECEASED: (First) <u>HENRY</u> (Middle) <u>Phillip</u> (Last) <u>Lohrey</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Oct 11 1903</u>	
				9. AGE last birthday: <u>51</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>City Police</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Phillip Henry Lohrey</u>				14. MOTHER'S MAIDEN NAME: <u>Jessie Solomon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>215-32-6288</u>		17. INFORMANT & ADDRESS: <u>Wesley M. Lohrey 4605 Elsode Ave Baltimore Md.</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary thrombosis, acute</u>			<u>15 months</u>
Antecedent cause(s) (b) <u>Arteriosclerotic C.V.D.</u>			<u>10 years</u>
260X Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Diabetes Mellitus</u>			<u>1 year</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>James W. Jr.</u>		CHIEF MEDICAL EXAMINER DATE SIGNED <u>June 25, 55</u>	
		DEPUTY MEDICAL EXAMINER	
		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 25, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 25, 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>Anna A. Burbage Berlin Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

BUREAU V. S.

JUN 28 1955

RECEIVED

6083

06089

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 350

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Rural - Stockton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
<i>Donald Stephen Loughran</i>		<i>June 4 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: <i>8/15/1949</i>
9. AGE last birthday: <i>5</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY:
<i>at home</i>		<i>Minthis Tenn</i>	<i>USA</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Donald Stephen Loughran</i>		<i>Nola C. Gent</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		<i>Donald S. Loughran</i>	
17. INFORMANT & ADDRESS:			
<i>Donald S. Loughran</i>		<i>Rural Stockton Md.</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<i>Fractured Skull</i>			
Immediate cause (a) DUE TO			
<i>Struck by an Automobile</i>			
Antecedent cause(s) (b) DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Stockton Rd. Worcester Md</i>	21c. City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>June 4 1955 3rd M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Struck by a Dodge Automobile</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>N. J. J. J.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>6/4/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>June 8-1955</i>	
NAME OF CEMETERY OR CREMATORY: <i>Remson ME Cemetery</i>		LOCATION (City, town, or county) (State): <i>Rural Pocomoke Md</i>	
DATE REC'D BY LOCAL REG. <i>June 8, 1955</i>		24. FUNERAL DIRECTOR: <i>Henry H. Watson</i>	
REGISTRAR'S SIGNATURE: <i>Anne E. White</i>		ADDRESS: <i>Pocomoke Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 10 1955

BUREAU V. S.

6784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Berlin, Worcester MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Route # 2
 OR TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Worcester
 CITY (If outside corporate limits, write RURAL and give nearest town) Berlin
 OR TOWN
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) JASPER (Middle) JAKE (Last) MURRELL
 (Type or Print)

4. DATE OF DEATH: (Month) 6 (Day) 9 (Year) 1955

5. SEX:

MALE

6. COLOR OR RACE:

A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH:

5-15-16

9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: Poultry

11. BIRTHPLACE (State or foreign country): Kinston, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Wilmer Murrell

14. MOTHER'S MAIDEN NAME:

CORA Pridgens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 243-16-3153

17. INFORMANT & ADDRESS:

Mrs. Ida Wade, Berlin, Md. P.O. Box 183

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
 Immediate cause

(a) DUE TO

Antecedent causes (s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Coronary thrombosis
Acute myocardial infarction

Interval Between Onset And Death
10-15 min

4 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While at Work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/5, 1955, to 6/8, 1955, that I last saw the deceased alive on 6/8, 1955, and that death occurred at 1:30 PM 6/9/55 from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION, REMOVAL (Specify)

BURIAL
 DATE REC'D BY LOCAL REGISTRAR 6-12-55

DATE THEREOF

6-12-55

NAME OF CEMETERY OR CREMATORY

EVERGREEN Cemetery

LOCATION (City, town, or county)

Berlin

(State)

md

REGISTRAR'S SIGNATURE

Robert Hayward

24. FUNERAL DIRECTOR

STEWART FUNERAL HOME

ADDRESS

Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 14 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06091

6085

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishop, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishop</u>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>Peter</u> (Middle) <u>Pastley</u> (Last)		4. DATE OF DEATH <u>June</u> (Month) <u>20</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1870</u>
9. AGE last birthday <u>85</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>garment</u> b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Pastley</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Carey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Addie P. Pastley</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>5 yrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>446X</u> Immediate cause <u>(a) Hypertension & nephrosclerosis, chronic,</u> Antecedent cause(s) <u>(b) Atherosclerosis, generalized</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c)</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1955, to 20 June, 1955, that I last saw the deceased alive on 20 June, 1955, and that death occurred at 6:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE <u>June 23, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Whaleyville</u>	LOCATION (City, town, or county) (State) <u>Whaleyville Md.</u>
DATE REC'D BY LOCAL REG. <u>June 29, 1955</u>	REGISTRAR'S SIGNATURE <u>Hilda Bergeson</u>	24. FUNERAL DIRECTOR <u>Henry W. Watson</u>	ADDRESS <u>Pocomoke City Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 29 1955

RECEIVED

6086

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write and give nearest town) OR TOWN <i>Snow Hill</i>	LENGTH OF STAY (in this place) <i>2 months</i>	CITY (If outside corporate limits, write and give nearest town) OR TOWN <i>Pocomoke City</i> <i>42</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Leigh</i>	(Middle) <i>Anna</i>	(Last) <i>Richardson</i>	
(Sex) <i>Female</i>		DATE OF DEATH <i>June 12 1955</i>	
5. SEX:	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH: <i>June 20 - 1923</i>
			9. AGE last birthday <i>31 11/11/52</i> yrs.
			IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even retired): <i>Housewife</i>	10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	11. BIRTHPLACE (State or foreign country): <i>Hallwood, Virginia</i>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME: <i>John W. Northam</i>	14. MOTHER'S MAIDEN NAME: <i>Kizzie Spence</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT & ADDRESS: <i>M. J. Dawson Richardson, Snow Hill, md</i>
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18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
239X IMMEDIATE CAUSE	(A) <i>Cachexia and inanition</i>	<i>3 wks</i>
ANTECEDENT CAUSE (S)	(B) <i>Mixed Cell Tumor of the Right</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.	(C) <i>Submaxillary Salivary Gland,</i>	<i>1 yr.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *April 1, 1955*, to *June 12, 1955*, that I last saw the deceased alive on *June 11, 1955*, and that death occurred at *6:30 P.M.*, from the causes and on the date stated above.

SIGNATURE <i>Leigh A. LaMar</i>	DATE SIGNED <i>6-13-55</i>
23. BURIAL, CREMATION, or other disposal (SPECIFY) <i>Burial</i>	DATE THEREOF <i>June 14/55</i>
NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	LOCATION (City, town, or county) (State) <i>Imperialville Virginia</i>
DATE REC'D BY LOCAL REGISTRAR <i>June 14, 55</i>	REGISTRAR'S SIGNATURE <i>Clayton E. Cooper</i>
FUNERAL DIRECTOR'S SIGNATURE <i>Clayton E. Cooper</i>	ADDRESS <i>Snow Hill, md</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 28 1955

RECEIVED

6087

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	LENGTH OF STAY (in this place) <u>2 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>	TOWN <u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>503 Balto. Ave</u>		STREET ADDRESS (If rural give location) <u>503 Balto. Ave.</u>	
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>Alfred</u> (Last) <u>Vawter</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 16 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 7, 1872</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, with "retired") <u>Retired Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John W. Vawter</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>719-05-6831</u>	
17. INFORMANT'S ADDRESS: <u>Mrs Agnes V. Patterson Ocean City, Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Interosclerotic Cardio renal disease</u>		<u>3 years</u>	
ANTECEDENT CAUSE (B) <u>Chronic pyelonephritis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>1 year</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.	
21b. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1953</u> to <u>June 16, 1955</u> ; that I last saw the deceased alive on <u>June 16, 1955</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>June 16, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 19, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 21, 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. I.

JUN 21 1955

RECEIVED